No. 84483-6

IN THE SUPREME COURT
OF THE STATE OF WASHINGTON

THE CITY OF SEATTLE, a municipal corporation,	)	
Petitioner,	)	PETITION AGAINST STATE OFFICER ROBERT MCKENNA; WRIT OF MANDAMUS
vs.	)	
ROBERT M. MCKENNA, Attorney General, Washington State,	)	
Respondent.	)	

Petitioner alleges:

I. NATURE OF THE ACTION

1. Petitioner seeks a writ of mandamus to compel Respondent Robert M. McKenna to withdraw the State of Washington from the case of *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, Case No. 3:10-cv-91, filed in the United States District Court for the Northern District of Florida on March 23, 2010 (the "Florida lawsuit"), and to cease participating in that case. Petitioner seeks the writ on the grounds that the Attorney General exceeded his authority when he made the State of Washington a plaintiff in that case. In the alternative, if this

Court declines to exercise its original jurisdiction and transfers this matter to superior court, then Petitioner also seeks a writ of prohibition to bar Respondent from participating further in the Florida case.

II. PARTIES

A. Petitioner.

2. Petitioner the City of Seattle is a municipal corporation and a First Class city, located in King County, Washington.

3. Petitioner provides primary medical and dental care to people who are uninsured or underinsured. In 2010, Seattle has committed over $6 Million to provide such care in community health centers. Exhibit A (Seattle Human Services Department online information).

4. Petitioner also provides: pre-natal and post-natal care to adolescent pregnant women (more than $500,000 in 2010); case management for people with HIV/AIDS ($225,000 in 2010); dental screenings and tooth sealants for minority and low-income students (more than $125,000 in 2010); prevention of infant mortality ($114,000 in 2010); school based health services (nearly $4 Million in 2010); and, chemical dependency intervention and treatment (more than $700,000 in 2010). *Id.*

5. Public health data indicates major disparities in health outcomes based on health insurance status. Exhibit B (Seattle Human Services Department, Strategic Investment Plan Update 2008-10, p.30.

6. In 2005, Petitioner submitted an advisory ballot measure concerning health care to the people of Seattle asking whether the voters agree that "Every person in the United States should have the right to health care of high quality and the Congress should immediately enact legislation to implement this right." The measure was approved by 69.5 percent of the voters. Exhibit C(City Council Resolution No. 31196)

7. The Seattle City Council adopted a Resolution on March 25, 2010, with the Mayor concurring, supporting enactment of the Patient Protection and Affordable Care Act and opposing Attorney General McKenna's participation in the case challenging it. *Id.*

B. Respondent.

8. Robert M. McKenna is the Attorney General of Washington State.

III. JURISDICTION

9. This Court has original jurisdiction over a petition against a state officer under Article 4, Section 4 of the Constitution of the State of Washington. *See* RAP 16.2.

10. A writ of mandate may be issued to prohibit a state officer from acting in a manner that exceeds his or her authority. *State ex rel. O'Connell v. Yelle,* 61 Wn.2d 620, 320 P.2d 1086 (1958).

11. It is appropriate for the Supreme Court to exercise original

jurisdiction over a petition for a writ when "the application involves the interests of the state at large, or of the public. . . ." *ITT Rayonier Inc. v. Hill,* 78 Wn.2d 700, 706, 478 P.2d 729 (1970). The matter at issue is the scope of the Attorney General's authority, particularly, whether he had authority to make the State of Washington a plaintiff in the federal case challenging the Patient Protection and Affordable Care Act. That issue plainly involves the interests of the state at large and of the public.

IV. STATEMENT OF THE CLAIM

A. Scope of the Attorney General's Authority.

12. The Washington constitution provides that, "The Attorney General shall be the legal adviser of the state officers, and shall perform such other duties **as may be prescribed by law**. Wash. Const. art. 3, § 21*(emphasis added).* When the term "as may be prescribed by law" is used in the constitution, it means the officer has only the powers expressly given by the state legislature. He has no common law powers. *Yelle v. Bishop,* 55 Wn.2d 286, 295-96, 347 P.2d 1081 (1959); *State ex rel. Winston v. Seattle Gas & Electric Co.,* 28 Wash. 488, 497, 68 P. 946 (1902).

13. Since the Washington Attorney General does not have broad common law powers and the constitution does not grant him any authority other than what is set forth in statutes, then we must look to the state's statutes to determine what authority has been granted to him. Under the

principle statute, the Attorney General shall:

(1) Appear for and represent the state before the supreme court or the court of appeals in all cases in which the state is interested;

(2) Institute and prosecute all actions and proceedings for, or for the use of the state, which may be necessary in the execution of the duties of any state officer;

(3) Defend all actions and proceedings against any state officer or employee acting in his or her official capacity, in any of the courts of this state or the United States;

(4) Consult with and advise the several prosecuting attorneys in matters relating to the duties of their office, and when the interests of the state require, he or she shall attend the trial of any person accused of a crime, and assist in the prosecution;

(5) Consult with and advise the governor, members of the legislature, and other state officers, and when requested, give written opinions upon all constitutional or legal questions relating to the duties of such officers;

(6) Prepare proper drafts of contracts and other instruments relating to subjects in which the state is interested;

(7) Give written opinions, when requested by either branch of the legislature, or any committee thereof, upon constitutional or legal questions;

(8) Enforce the proper application of funds appropriated for the public institutions of the state, and prosecute corporations for failure or refusal to make the reports required by law;

(9) Keep in proper books a record of all cases prosecuted or defended by him or her, on behalf of the state

> or its officers, and of all proceedings had in relation thereto, and deliver the same to his or her successor in office;
>
> (10) Keep books in which he or she shall record all the official opinions given by him or her during his or her term of office, and deliver the same to his or her successor in office;
>
> (11) Pay into the state treasury all moneys received by him or her for the use of the state.

RCW 43.10.030. None of the provisions of RCW 43.10.030 grant authority for the Attorney General to act unilaterally to make the State of Washington a plaintiff in the Florida lawsuit without the Governor's concurrence.

14. The first section of RCW 43.10.030 is expressly limited to the courts of appeals and the supreme court. The Attorney General may represent the state in trial proceedings when authorized by another statutory provision, such as RCW 43.10.030(2) and (3), but neither of those sections is applicable to the Florida lawsuit. Section (2) applies to situations in which a state officer requires legal representation to fulfill his or her duties, such as the enforcement of state regulations. Section (3) relates to the defense of state officers, but the Florida lawsuit is not such an action. None of the other sections even arguably apply to the present situation.

15. Other state statutes authorize the Attorney General to act in specific situations, none of which apply to the present case. See, e.g., RCW 42.17.400 (Attorney General may bring civil action to enforce state

campaign financing law); RCW 42.52.490 (Attorney General may bring a civil action to enforce the state ethics code); RCW 19.86.080 (Attorney General may enforce the consumer protection statute).

16. In Washington, unlike some other states, the constitution gives the Governor "supreme executive power." Wash. Const. art. III, § 2. The Attorney General is one of the "other" executive officers. *Id.,* art. III, § 3. By statute the Governor, "shall supervise the conduct of all executive offices." RCW 43.060.010(1).

17. The Governor's constitutional duties include the duty to "see that the laws are faithfully executed." Wash. Const. art III, § 5. The Governor has specific authority over the Attorney General, including authority to: direct the Attorney General to appear on behalf of the state when a lawsuit may result in a claim against the state, RCW 43.06.010(5); require the Attorney General to investigate corporations, RCW 43.06.010(6), and; require the Attorney General to aid a county prosecuting attorney. RCW 43.06.010(7).

B. The Attorney General's Actions.

18. On March 23, 2010, Respondent Robert M. McKenna, along with the attorneys general of twelve other states, filed a complaint in the United States District Court for the Northern District of Florida ("the Complaint"). Exhibit D (Complaint filed in *State of Florida, et al. v. United*

States Department of Health and Human Services, et al., Case No. 3:10-cv-91).

19. Respondent purported to file the Complaint on behalf of the State of Washington.

20. The Complaint alleges that key parts of the Patient Protection and Affordable Care Act violate the Constitution of the United States.

21. The Complaint seeks a declaratory judgment and injunctive relief. Such relief is allegedly sought by the plaintiff states, including Washington State, "to preserve their respective sovereignty and solvency. . ."

22. The Complaint alleges that, "The Act greatly alters the federal-state relationship, to the detriment of the states, with respect to Medicaid programs specifically and healthcare coverage generally."

23. The Complaint alleges that the Act will have a similar impact on all the plaintiff states as it allegedly will on Florida, and then goes into specifics regarding the alleged impact on Florida.

24. The Complaint alleges that the plaintiff states, "cannot afford the exorbitant and unfunded costs of participating under the Act, but have no choice other than to participate."

25. Respondent filed the Complaint without prior consultation with the Governor of the State of Washington and without her direction or consent.

26. Respondent did not file the Complaint on behalf of any Washington State agency or official, rather he purported to file it on behalf of the state itself in its sovereign capacity. When the Governor learned he had filed the complaint, she objected strenuously. Exhibit E (Letter from Governor Gregoire and other state governors to United States Attorney General Eric Holder).

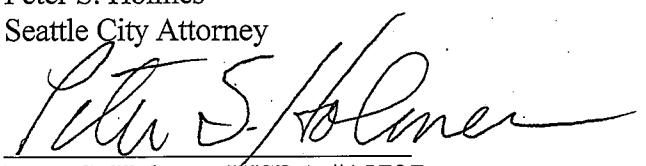
C. Relief Requested.

Petitioner respectfully asks this Court to issue a writ of mandamus compelling the Attorney General to withdraw the State of Washington from the Florida lawsuit. Specifically, Petitioner requests the following writ of mandamus:

> Respondent, Attorney General Robert M. McKenna, is hereby ordered to file the necessary pleadings in the United States District Court for the Northern District of Florida to withdraw the State of Washington from the case of *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, Case No. 3:10-cv-91. Respondent shall comply with this order within ten court days of the issuance of this writ.

RESPECTFULLY SUBMITTED this 22nd day of April, 2010.

Peter S. Holmes
Seattle City Attorney

By: 

Peter S. Holmes, WSBA #15787
Laura Wishik, WSBA #16682
Seattle City Attorney's Office
600 – 4th Ave., 4th Floor
PO Box 94769
Seattle, WA 98124-4769
(206)684-8200
Attorney for Petitioner

MICHELE Y. WORTHY certifies under penalty of perjury under the laws of the State of Washington that the following is true and correct.

I am employed as a Legal Assistant with the Seattle City Attorney's office.

On April 22, 2010, I requested ABC-Legal Process Servers to serve, by 5:00 p.m, 2010, a copy of the "Petition Against State Officer Robert McKenna; Writ of Mandamus or Writ of Prohibition" and this "Proof of Service" upon:

Robert M. McKenna
6021 – 118th Ave SE
Bellevue, WA 98006

and to file the original of said documents by April 22, 2010, with the Supreme Court of the State of Washington.

DATED this 22nd day of April, 2010.

MICHELE Y. WORTHY

Seattle City Attorney's Office
600 Fourth Avenue, 4th Floor
PO Box 94769
Seattle, WA 98124-4769
(206) 684-8200

CERTIFICATION OF AUTHENTICITY OF EXHIBITS

I am one of the attorneys for Petitioner, the City of Seattle and I certify that the attached documents are true and correct copies of the originals. The attachments are:

A. Seattle Human Services Department online information regarding public health services.

B. Excerpts from the Strategic Investment Plan Update 2009-20010, Seattle Human Services Department.

C. Resolution No. 31196, adopted by the Seattle City Council on March 24, 2010 and signed by the Mayor of Seattle on March 25, 2010.

D. Complaint filed in the case *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, Case No. 3:10-cv-91 (United States District Court for the Northern District of Florida).

E. Letter dated March 26, 2010 from Washington Governor Christine Gregoire and the Governors of Pennsylvania, Colorado, and Michigan, to United States Attorney General Eric Holder.

Signed this 22nd day of April, 2010.

Laura Wishik

Laura B. Wishik, WSBA #16682

EXHIBIT A

Services and Programs

- Children & Families
- Community Development Block Grant
- Domestic Violence & Sexual Assault Prevention
- Education & Employment
- Emergency Services & Ending Homelessness
- Financial Assistance / PeoplePoint
- **Food & Health**
  - Food Programs & Services
  - Public Health Initiatives & Funding
  - Healthy Communities Initiatives
  - Public Health Indicators
  - Public Health Programs & Services
- Immigrants & Refugees
- Seniors & Adults with Disabilities
- Youth Services

Public Health Initiatives and Funding

Community Health Centers: Primary Medical & Dental Care

Low-income, uninsured and underinsured people commonly lack the ability to pay for health care, and significant health disparities exist for those living in poverty. For this reason, the City of Seattle funds Seattle's community health centers. These centers help assure better access to health care for people living in Seattle.

The centers offer primary medical and dental care to those who would not otherwise get it. Regardless of ability to pay, low-income, uninsured and underinsured people are offered health services, including management of chronic health conditions, on a discounted or sliding scale basis. The centers also help individuals and families with enrollment in government-funded health insurance packages.

City funding is allocated to Seattle community health centers through Public Health-Seattle & King County, the agency responsible for overseeing community health center programs funded by the City.

Asthma Prevention

Best Beginnings for Pregnant Adolescents

Community Health Centers: Primary Medical & Dental Care

HIV / AIDS Prevention & Services

Oral Health for Children

Outreach and Access to Health Care

Infant Mortality Prevention Network

School-based Health Centers

Substance Abuse

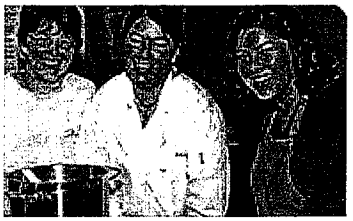
Health Emergency and Virus Information Sources

The City of Seattle started funding Community Based Health Centers in the late 1970s. In 2008, we spent $6.2 million in City General Funds on the centers.

City of Seattle General Fund allocations to health care agencies are determined through a competitive process conducted by the Seattle Human Services Department. Funding during funding cycles depends upon program performance and revenues. We are providing $6,284,074 in 2010.

2010 Funded Agencies and Programs

- Children's Hospital Regional Health Center
  - Odessa Brown Children's Clinic (dental)
- Country Doctor Community Health Center
  - Carolyn Downs Family Medical Center (medical only)



Services and Programs

- Children & Families
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- Youth Services

Public Health Initiatives and Funding

Best Beginnings for Pregnant Adolescents

Pregnant adolescents are at higher risk for anemia and dropping out of school, and their infants are at higher risk for a low birth weight, infant mortality and abuse and neglect.

Best Beginnings, the local arm of the National Nurse Family Partnership administered by Public Health – Seattle & King County, promotes healthy child development by providing public health nursing services to low-income, adolescent women who are pregnant for the first time. Eighty-five percent of the mothers served are from minority communities who don't have good access to health care. They are enrolled prior to 28 weeks of pregnancy and are followed until the children are two years old.

Services include in-home nurse visits; health assessments of the mother and infant; health education; child development evaluation; and referrals to prenatal care, health insurance, housing, child care, public assistance, school, work training and other services. Best Beginnings services have proven to be effective in improving birth and infant health outcomes, increasing young mothers' engagement in school or work, and decreasing incidents of child abuse and neglect.

Asthma Prevention

Best Beginnings for Pregnant Adolescents

Community Health Centers: Primary Medical & Dental Care

HIV / AIDS Prevention & Services

Oral Health for Children

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School-based Health Centers

Substance Abuse

Health Emergency and Virus Information Sources

The City of Seattle has funded Public Health - Seattle & King County for Best Beginnings since 2002. In 2010, we are providing $539,816 toward the total program operating budget of approximately $1.2 million.

Information

For more information about Best Beginnings call 206-205-7273.

For more information about City of Seattle public health programs and services, call 206-684-0684 or e-mail publichealth@seattle.gov.

For information about related programs, visit:

Services and Programs

- Children & Families
- Community Development Block Grant
- Domestic Violence & Sexual Assault Prevention
- Education & Employment
- Emergency Services & Ending Homelessness
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Public Health Initiatives and Funding

HIV / AIDS Prevention & Services

HIV/AIDS Case Management services are administered by Public Health - Seattle & King County to help persons living with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) to access and maintain consistent medical care and treatment, and improve their quality of life. Services include education on how to prevent the transmission of the disease to others, and links to culturally appropriate supportive services such as mental health, substance abuse treatment, housing, transportation and food.

The Ryan White CARE Act has provided federal funds for this national program since the early 1980s and is the primary source of funding. However, there are more Seattle residents living with HIV/AIDS than what these federal funds cover, so City investments expand this program's capacity to provide case management services, which include needs assessments and referrals.

Asthma Prevention

Best Beginnings for Pregnant Adolescents

Community Health Centers: Primary Medical & Dental Care

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Health Emergency and Virus Information Sources

2010 Funded Agencies and Programs

- Consejo Counseling and Referral
- Harborview Medical Center — Madison Clinic
- Jail Health Services (two King County correctional facilities)
- Lifelong AIDS Alliance
- People of Color Against AIDS Network
- Country Doctor Community Health Clinics

The City of Seattle has provided funds for HIV/AIDS Case Management services since 1996. The City General Funds are allocated through Public Health - Seattle & King County, the agency that oversees the programs. In 2010, the City is providing $227,851 for this program, $33,388 to the Perinatal HIV Consortium, and $153,750 for enhanced HIV/AIDS prevention strategies that will include expanded testing at the following sites:

- Country Doctor Community Clinics
- Gay City Wellness Center

Services and Programs

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Public Health Initiatives and Funding

Oral Health for Children

Oral health is essential to the development and well-being of children. Studies show that children living in low-income, minority communities in Seattle are at highest risk for tooth decay.

The Community Based Oral Health Program, managed by Public Health – Seattle & King County, seeks to reduce dental health disparities by providing dental screenings, health education, decay-preventing tooth sealants for 2nd and 3rd-grade students, and referrals to private providers, public health dental clinics and community health center dental clinics.

During the school year, the program sends a team of dental hygienists and dental assistants with portable equipment to 25 public elementary schools, child care centers and Head Start programs in Seattle.

The City of Seattle has funded the Community Based Oral Health Program since 1986. Funds from the City are allocated to Public Health – Seattle & King County, the agency responsible for overseeing the program. In 2010, we are committing $125,119 in General Funds.

Asthma Prevention

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Infant Mortality Prevention Network

School-based Health Centers

Substance Abuse

Health Emergency and Virus Information Sources

Information

For more information about this program, visit the Community Based Oral Health Program Web site.

For more information about City of Seattle public health programs and services, call 206-684-0684 or e-mail publichealth@seattle.gov.

For more information about our partners and similar programs, visit:

- Washington State Department of Health Oral Health Program

Services and Programs

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Public Health Initiatives and Funding

Infant Mortality Prevention Network

While the overall infant mortality rate in King County has gone down over the last 20 years, infant mortality rates for African Americans and American Indian/Alaska Natives continue to experience infant mortality rates more than two times higher than other groups.

The Infant Mortality Prevention Network includes four community-based agencies that promote healthy pregnancies and reduce infant mortality. The Network's agencies conduct outreach and education, and provide referrals for prenatal care, labor support, chemical dependency treatment, housing and basic needs support for high-risk pregnant adolescents.

The City of Seattle has funded infant mortality programs since the early 1990s and other access and outreach services since 2001. City of Seattle General Funds are allocated through Public Health - Seattle & King County, the agency responsible for overseeing the program. In 2010, the City will allocate $114,605 for the Infant Mortality Prevention Program.

Asthma Prevention

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Oral Health for Children

Outreach and Access to Health Care

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School-based Health Centers

Substance Abuse

Health Emergency and Virus Information Sources

Information

For more information about City of Seattle public health programs and services, call 206-684-0684 or e-mail publichealth@seattle.gov.

For more information about our partners and related programs, visit:

- Infant Mortality Prevention Network, 206-263-8366
- Infant mortality resources:

  Data Watch: Racial Disparities in Infant Mortality: An Update - King County - 1980-2002

  The Health of King County 2006, Chapter4: Maternal & Infant Health

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Public Health Initiatives and Funding

School-based Health Centers and School Nurses

Success and economic opportunity in life can be directly linked to the level of education a young person attains. The City of Seattle invests in School-Based Health Centers and School Nurses to keep children who aren't performing well academically healthy and in school.

Ten public high schools and four middle schools in Seattle have a health center. These centers provide health assessment and services include nursing care, mental health services, management of chronic illnesses, prevention programs and immunizations. School nursing services provides screening for academic risk and population-based health services across health center sites and other programs.

The City of Seattle has funded school-based health centers since the early 1990s. City Families and Education Levy funds are allocated through Public Health-Seattle & King County, the agency responsible for overseeing the program. During the 2009-2010 school year, we are spending more than $3.9 million on school based health centers and school nurses.

Asthma Prevention

Best Beginnings for Pregnant Adolescents

Community Health Centers: Primary Medical & Dental Care

HIV / AIDS Prevention & Services

Oral Health for Children

Outreach and Access to Health Care

Infant Mortality Prevention Network

School-based Health Centers

Substance Abuse

Health Emergency and Virus Information Sources

Funded Agencies and Programs for the 2009-2010 School Year

- Group Health Cooperative
  Aki Kurose Middle School
  Franklin High School
  Nathan Hale High School
  Washington Middle School
- Odessa Brown at Children's Regional Medical Center
  Garfield High School
- Public Health - Seattle & King County
  Cleveland High School
  Ingraham High School
  Rainier Beach High School

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Public Health Initiatives and Funding

Substance Abuse

Active drug and alcohol abuse within a community results in loss of job productivity, transmission of illness through intravenous drug use, drug-related crimes, incarceration, homelessness and more. The National Institute on Drug Abuse says substance abuse prevention and treatment programs are substantially less expensive than the social and economic costs of active alcohol and drug abuse.

For this reason and for the health of our residents, the City of Seattle invests in substance abuse prevention and treatment services:

- Chemical Dependency Interventions
- Emergency Services Patrol
- Methadone Treatment
- Needle Exchange Program
- Youth Engagement Program
- Multisystemic Therapy Program

Asthma Prevention

Best Beginnings for Pregnant Adolescents

Community Health Centers: Primary Medical & Dental Care

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Substance Abuse

Health Emergency and Virus Information Sources

Chemical Dependency Interventions

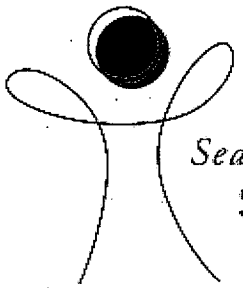
Chemical Dependency Interventions, managed by the King County Department of Community and Human Services, help people who are in crisis with their chemical dependency. Approximately 600 Seattle residents are treated for chemical dependency problems and related behavioral crises each year at Harborview Medical Center.

On-site chemical dependency screening and assessment address the crisis and refer patients to chemical dependency treatment. Services include detoxification, next-day appointments for treatment, and case management especially for those individuals identified as the highest users of Harborview's Psychiatric Emergency Services.

Emergency Services Patrol

The Emergency Services Patrol, managed by the King County Department of Community and Human Services, responds to 911 dispatch calls regarding chronic public inebriates or incapacitated individuals on the streets of Seattle who are in crisis. Emergency Services Patrol members provide direct assistance, assessment and transportation, and therefore allow police and fire personnel to respond to other 911 crisis calls and emergencies.

EXHIBIT B



Seattle HUMAN SERVICES Department

Strategic Investment Plan Update

2008–2010

Updated May 2008

City of Seattle

"The moral test of a government is how it treats those who are at the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadow of life, the sick, the needy, and the handicapped."

– Hubert H. Humphrey

Policy Statement

Through their city government, the people of Seattle invest in many different assets that together build a strong, vibrant community. They invest in public utilities to provide clean water and electrical power, in fire and police forces to protect public safety, and in streets, parks, libraries and other resources that enhance the quality of life in our neighborhoods. Among the most important investments our city makes are services that promote the health and well-being of our community's most vulnerable members –children, elders and those in need.

The Seattle Human Services Department (HSD) is the City department that works to ensure that our most vulnerable community members are free from hunger, safe in their homes, obtain education and job skills to be economically self-sufficient, and maintain adequate health to live independently and with dignity. To fulfill this mission, HSD acts as leader, funder and service provider.

As a leader, HSD believes that government can and should be a catalyst for change. Initiatives undertaken by the department include a focus on social justice that targets racism and disproportionality in communities of color, and addresses other root causes of poverty. As a funder, HSD makes strategic investments in the community. We contract with more than 200 community-based organizations to provide high quality programs and services designed to achieve specific outcomes. As a direct service provider, HSD limits its role to situations in which the fund source requires a municipality to serve as a provider; when no viable community-based organization is available to provide a service; or when City administration is necessary to access another City resource.

Our challenge is to fulfill these responsibilities with the limited resources available.

Historical Context: Human Services

The City of Seattle's involvement in providing human services began in earnest during the Boeing recession of the early 1970s, when tens of thousands of factory workers were laid off, unemployment reached near-record levels and thousands of families lost their homes because they could not afford to pay their mortgages. Poverty was not new to Seattle. Many civil rights activists, concerned about poverty, housing and equity issues, created grassroots community-based organizations to address these issues and advocate for their communities with the City government. The Boeing recession, however, brought the issue of poverty into sharp focus with policy makers and the general public. In response to that crisis, volunteer food banks, health clinics, and community action agencies sprang up to meet the urgent needs of Seattle's people.

The City did not have a legal mandate to provide human services, nor the experience in managing human service programs. Previously, human services were viewed as a state and federal responsibility. However, Seattle's leaders could not ignore the hardships that were so evident among the populace, and organized a City department for human services (initially named the Department of Human Resources) to help the nonprofit community agencies that were taking the lead in responding to the challenge. At first, the City's role was as a conduit for federal funding, secured by Seattle's legendary senators Magnuson and Jackson, for the city's poor and unemployed. In this role, the City helped to reduce the human impact of the recession and, in the process, built strong partnerships with community-based organizations that have endured for more than three decades.

With the election of the Reagan administration in the early 1980s, federal funding for human services began a precipitous decline. During that same period, another recession gripped the Seattle area, and the combination resulted in tremendous pressures on the city's food banks, health clinics, and other human service agencies. To make matters worse, increasing numbers of people without homes sought refuge in Seattle's shelters and on its streets – local evidence of a national epidemic of homelessness. Faced with these realities, Mayor Charles Royer and the Seattle City Council decided in 1984 to begin using the City's own General Fund resources to provide the "survival services" necessary to help those most in need.

As the City government and its nonprofit partners gained experience, they became more effective in managing the complexities of providing services to the increasingly diverse populations of Seattle and in creating strategies for *preventing* poverty, as well as treating its symptoms. Working together, these partners began to shift the emphasis from simply providing shelter, food, and basic medical care to a broader spectrum of services designed to reintegrate disadvantaged populations within the social and economic life of the community, and provide them with the tools to succeed.

During the 1990s, the City began to focus its human services funding to support other community goals, such as improving the educational system and strengthening families. Under the leadership of Mayor Norm Rice, the City created a Families and Education Levy, approved by Seattle voters in 1990, that provided nearly $10 million a year for health care, family support workers, and other services for children and their families in direct support of the public schools. Today, the Families and Education Levy continues to fund many of the programs instituted in past levies. Under the leadership of Mayor Greg Nickels there is a sharper focus on preparing children to be ready for school, improving academic achievement, reducing disproportionality, and helping students complete school. Emphasis is placed on serving students and schools that have historically underperformed.

In the past several years, the City has focused on bringing City policies and investments into *alignment* with those of our partners, including King County and United Way of King County. The goal of alignment is to focus the community's resources on the most critical issues, and avoid duplication or wasted effort, so that more can be accomplished. An example of this effort is the *Ten-Year Plan to End Homelessness*. The Ten-Year Plan provides a framework for how the region will work together to address the issues that cause homelessness, and create the housing and supportive services needed to end homelessness. The plan is endorsed by City of Seattle, the Metropolitan King County Council and suburban cities throughout the county representing 84% of the county's population, as well as service organizations and faith communities throughout the county.

Hand-in-hand with that alignment is a focus on *measuring outcomes,* rather than simply counting the units of service provided. For example, if our goal is to reduce the number of homeless individuals, we should measure the number of people who find a permanent home, rather than counting the number of "bed nights" provided in our shelters. By focusing on outcomes, we can more accurately gauge what is working well and what must be improved, and make adjustments to become more effective.

Historical Context: Public Health

The City has long been involved in funding and overseeing public health services and activities in Seattle. For many years, the joint Seattle-King County Department of Public Health was administered by the City of Seattle. In the early 1990s, Washington State defined public health as county responsibility and King County assumed operational authority for the Health Department. Although it operates as a department of the King County government, Public Health – Seattle & King County remains a joint City-County department with both the King County Executive and the Mayor of Seattle appointing the director, with the concurrence of both the City and County councils.

King County has responsibility for core, regional public health services. The City's public health investments are voluntary and fund enhanced services for Seattle residents that King County does not provide as part of its regional core responsibilities. City funds also support greater service levels to increase the number of people in Seattle who are served.

In 2006, the City adopted the *Healthy Communities Initiative Policy Guide* that guides the City's public health efforts and investments. The Policy Guide outlines a vision, "*The People of Seattle will be the healthiest of any major city in the nation,*" and four goals: 1) Eliminate health disparities; 2) Promote access to clinical and preventive health services; 3) Protect and foster the health and well-being of communities; and 4) Support the fulfillment of other City goals.

In 2008, the City endorsed the King County Public Health Operational Master Plan, which establishes broad policies to prioritize and guide decision-making regarding public health services. The Master Plan is consistent with the City's Healthy Communities Initiative Policy Guide and reinforces the importance of addressing health disparities.

Race and Social Justice

In 2002, Mayor Nickels launched the Race and Social Justice Initiative (RSJI). The RSJI emphasizes the need to understand the historical and institutional factors that affect health and well-being, and how these factors may result in disparities and disproportionality in services to racial and cultural groups. The RSJI also promotes anti-racism and multiculturalism as assets and mandates that City departments examine programs and policies, including City investments, from an equity and anti-racist lens. HSD actively works towards developing an anti-racist, multicultural approach to policy and program development with the aim of reducing disparities and disproportionality, increasing access to our services, and treating all Seattle residents with dignity and respect.

Today's Climate and Challenges

In 2008, our City contributes nearly $68 million annually to health and human services through its General Fund and the Families and Education Levy[1]. Yet these resources, even when combined with the contributions of King County and United Way, fall well short of the need.

In the early part of the new millennium, our community faced two recurring challenges —the human impact of economic recession, and the devolution of federal and state responsibility for funding human services programs. The 2008 economic forecast indicates that the Puget Sound region will have slow but still positive economic growth in the next few years. However, the lack of affordable housing in Seattle, challenges for many to access living wage jobs - particularly jobs with health care benefits sufficient to meet family needs, the growth of our elder population, and the increasing complexity of human services needs, make the City's role in delivering human services challenging. Moreover, federal, and to a lesser extent state, responsibility continues to devolve to local communities, adding additional burdens on local funding. For example, federal Department of Labor funding for the Workforce Investment Act (WIA), a major source of funding for employment and training programs for low-income youth, has experienced significant reductions in the last five years due to federal cuts and formula driven changes impacting Seattle. Seattle's high employment rate

[1] This dollar amount refers to General Fund and Families and Education Levy dollars in the City's 2008 Adopted Budget.

and other factors are leading to an overall reduction of approximately 15% in WIA youth funding. Total reductions since 2003 are 25%. The Workforce Development Council has indicated that another 5% to 18% reduction in funding can be anticipated for 2008-09 fiscal year.

With a 5% increase in 2007 in the price of food and beverages locally (which translates at the grocery store to price increases of 29% for eggs, 7.4% for bread, and 23% for milk) more families struggle to put food on the table.[2] The demand for quality child care, employment, affordable housing, health care and elder care all continue to increase. In addition, the number of Seattle residents in need of vital culturally relevant and language-appropriate services to sustain themselves and their families continues to increase.

HSD must identify how its limited resources can have the greatest impact on the most critical problems. The SIP is intended to chart a course for meeting that challenge.

[2] Bureau of Labor Statistics, 2007

GOAL 4: HEALTH CARE TO BE AS PHYSICALLY AND MENTALLY FIT AS POSSIBLE

HSD plays a unique role in helping seniors and adults with disabilities maintain independence, economic stability, and community connections. For the past 30 years, HSD's Aging and Disabilities Division has been the designated Area Agency on Aging for the Seattle-King County region. In this capacity, HSD contracts for services, as well as directly serves the Seattle-King County region. Programs enhance the health, socialization and stability of vulnerable elders and adults with disabilities to maximize the quality of their lives and independence in the community.

In addition to work with seniors and adults with disabilities, HSD's work within this goal area also includes enhanced public health services. HSD has the responsibility to oversee the City's investments in public health and community health services. The City works in partnership with Public Health—Seattle & King County. King County has the responsibility to provide core, regional public health services.

The City recognizes that a continuum of public and community health services is necessary. This continuum addresses health needs identified in public health data across the lifespan including very young children, adolescents, pregnant women and older adults. The City's efforts and investments focus on eliminating health disparities, promoting access to clinical and preventive health services, and protecting and fostering the well-being of communities.

Key Strategies

- **Meet the basic needs of seniors and people with disabilities** through a network of community supports. Programs include case management, chronic care management, health promotion, and caregiver training and support for unpaid family caregivers to elders and people with disabilities.
- **Increase health and wellness of vulnerable populations** through health promotion activities at senior and community centers, chronic conditions and medication management for seniors and disabled adults, and family caregiver programs that includes in-home and out-of-home respite care services.
- **Increase senior social engagement** opportunities through senior centers and senior volunteer programs.
- **Improve independence for frail older adults** through outreach, case management, adult day care and other services designed to provide a safety net for frail older adults.
- **Enhance the public's health** through public health services designed to supplement core services provided through the Public Health Department.

Community Indicators

- Increased percentage of people age 65 years and older who report being in good to excellent health
- Increased quality and years of healthy life, and reduced health disparities.

Community Findings

- **Seattle's Aging Population** – Twelve percent of Seattle's population are 65 years of age or older – Seattle is fourth in the nation for concentration of people in this age bracket.[26] Nearly one quarter of Seattle's households are home to someone over the age of 60.[27] The population of older adults in King County is expected to grow by 40% between 1990 and 2010, to more than 313,000.[28]
- **Need for Caregiver Support** – Last year, 7,136 family caregivers contacted the caregiver information and assistance lines for support and more than 2,295 family caregivers received in-depth assistance in King County.[29] More people are requiring care, while the number of available caregivers is decreasing. Seniors in Seattle are more likely to live on their own than those in the surrounding region, Washington State, and the U.S.
- **Health Disparities Across Ethnic Groups** – Public Health data analysis shows that there are significant disparities in health outcomes based on race, ethnicity, income immigrant/refugee status, health insurance status, and neighborhood. These disparities are consistent across most health indicators. There are also major disparities based on gender, affecting both women and men. In addition, disparities tend to be interrelated; for example, there is a correlation between race and income level. People who are part of more than one disadvantaged group that experiences disparities may experience greater health problems.
- **Seattle's Population of Adults with Disabilities**[30] – Thirty percent of Seattle residents report some type of disability, including sensory, physical, mental, and self-care disabilities. Individuals between the ages of 16 and 64 account for 65% of all reported disabilities. The rate of growth in disabling conditions for younger adults is increasing.

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[26] 2006 American Community Survey, US Census Bureau

[27] Ibid.

[28] Public Health – Seattle & King County, *Living Longer Staying Healthy: The Health Status of Older Adults in King County,* January 1995

[29] City of Seattle Human Services Department, Aging and Disability Division 2007 contract performance data

[30] 2006 American Community Survey, US Census Bureau

Initiatives/Catalysts for Change

- In addition to direct and contracted services, the Area Agency on Aging also engages in **systems change efforts** that have lasting impacts on systems that support elders and people with disabilities. For example, HSD has made deliberate funding decisions to provide outreach and case management activities to reduce the health disparities that persist among racial and ethnic groups and to fund programs that modify risk factors associated with chronic disease and depression.

- HSD engages in **advocacy** efforts at the state level to improve the system of care for elders and people with disabilities. HSD recently worked with groups statewide to increase the wages of long-term care workers by $1 an hour, which supports both the quality of care for elders and addresses social justice issues. Long-term care workers, often women and/or people of color, historically have not earned a living wage.

- The City invests in **enhanced public health services** for the purpose of improving health outcomes for Seattle residents and communities, outcomes that could not be expected from providing core, regional public health services alone. The Healthy Communities Initiative (HCI) guides the City's public health efforts and investments, providing the policy framework for the City's role in public health. The HCI outlines four broad strategies for the City: 1) investments; 2) partnerships with Public Health—Seattle & King County, the University of Washington, and other public, community-based and private health-related organizations; 3) City services and policies that affect the public's health; and 4) opportunities to promote promising community-based and collaborative strategies to achieve better health outcomes.

Future Work

HSD will work to ensure that the Seattle-King County region is an "Elder-Friendly Community," one that provides elders' basic needs of food, shelter and safety; promotes health, social connections and systems that support access to services; and furthers civic engagement that can make aging issues a communitywide priority.

HSD is also supporting development of strategies that will help ensure that Seattle is a good place for baby boomers to retire. Actions will include policy, programmatic, and communications strategies for multiple departments in order to create an aging-friendly community where baby boomers can stay healthy, afford to live, and use time in meaningful ways, including participation in lifelong learning and recreation.

EXHIBIT C

Resolution No. 31196

A RESOLUTION supporting enactment of the federal Patient Protection and Affordable Care Act for reform of health care insurance and opposing efforts by Washington Attorney General Rob McKenna to participate in a lawsuit challenging the constitutionality of the Act.

Related Legislation File:

Date Introduced and Referred	To (committee)
3.29.10	Full Council
Date Re-referred	To (committee)
Date Re-referred	To (committee)
Date of Final Action	Date Presented to Mayor
3.29.10	3.29.10
Date Signed by Mayor	Date Returned to City Clerk
3.25.10	3.25.10
Published by Title Only	Date Returned Without Concurrence
Published in Full Text	

The City of Seattle – Legislative Department

Resolution sponsored by: Richard Conlin

Committee Action:

Date	Recommendation	Vote

This file is complete and ready for presentation to Full Council.

Full Council Action:

Date	Decision	Vote

Laura Wishik; JMS
Health Care resolution
March 23, 2010
Version # 7

RESOLUTION 31196

A RESOLUTION supporting enactment of the federal Patient Protection and Affordable Care Act for reform of health care insurance and opposing efforts by Washington Attorney General Rob McKenna to participate in a lawsuit challenging the constitutionality of the Act.

WHEREAS, Seattle's residents include many people who lack health care insurance or who are underinsured; and

WHEREAS, the City submitted an advisory ballot measure concerning health care to the people of Seattle in 2005 asking whether the voters agree that "Every person in the United States should have the right to health care of high quality. The Congress should immediately enact legislation to implement this right," which was approved by 69.5 % of the voters; and

WHEREAS, the City of Seattle provides services to seniors, youth, people who are homeless, and people of low incomes who will benefit greatly from the federal Patient Protection and Affordable Care Act; and

WHEREAS, the federal Patient Protection and Affordable Care Act is a necessary and reasonable step toward providing health care for all people in our great country; NOW, THEREFORE,

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF SEATTLE, THE MAYOR CONCURRING, THAT:

section 1. The City of Seattle supports enactment of the federal Patient Protection and Affordable Care Act for reform of health care insurance as a necessary and reasonable step toward providing health care for all people in our great country.

Section 2. The City recognizes that the federal Patient Protection and Affordable Care Act will directly benefit many people in Seattle who lack health care insurance or who are underinsured.

Section 3. The City supports Washington Governor Christine Gregoire's position that the Patient Protection and Affordable Care Act is in the interests of the State of Washington and is a

constitutional exercise of Congress' powers, and opposes the position Washington Attorney General Rob McKenna has taken in a lawsuit challenging the constitutionality of the Patient Protection and Affordable Care Act, purportedly on behalf of the State of Washington.

Section 4. The City also supports action by the State Legislature to prevent the Attorney General from participating in, or using state funds to support, litigation opposing federal health care reform.

Section 5. It is a City purpose and in the interests of the people of Seattle that City agencies, including the Office of Intergovernmental Relations and the City Attorney's Office, take whatever actions necessary to support the Patient Protection and Affordable Care Act.

Adopted by the City Council the 24th day of March, 2010, and signed by me in open session in authentication of its adoption this 24th day of March, 2010.

President _____ of the City Council

THE MAYOR CONCURRING:

Michael McGinn, Mayor

Filed by me this 25th day of March, 2010.

City Clerk

(Seal)

EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through BILL McCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA;

STATE OF SOUTH CAROLINA, by and through HENRY McMASTER, ATTORNEY GENERAL OF THE STATE OF SOUTH CAROLINA;

STATE OF NEBRASKA, by and through JON BRUNING, ATTORNEY GENERAL OF THE STATE OF NEBRASKA;

STATE OF TEXAS, by and through GREG ABBOTT, ATTORNEY GENERAL OF THE STATE OF TEXAS;

STATE OF UTAH, by and through MARK L. SHURTLEFF, ATTORNEY GENERAL OF THE STATE OF UTAH;

STATE OF LOUISIANA, by and through JAMES D. "BUDDY" CALDWELL, ATTORNEY GENERAL OF THE STATE OF LOUISIANA;

STATE OF ALABAMA, by and through TROY KING, ATTORNEY GENERAL OF THE STATE OF ALABAMA;

STATE OF MICHIGAN, by and through MICHAEL A. COX, ATTORNEY GENERAL OF THE STATE OF MICHIGAN;

STATE OF COLORADO, by and through JOHN W. SUTHERS, ATTORNEY GENERAL OF THE STATE OF COLORADO;

COMMONWEALTH OF PENNSYLVANIA, by and through THOMAS W. CORBETT, Jr., ATTORNEY GENERAL OF THE COMMONWEALTH OF PENNSYLVANIA;

STATE OF WASHINGTON, by and through ROBERT M. McKENNA, ATTORNEY GENERAL OF THE STATE OF WASHINGTON;

STATE OF IDAHO, by and through LAWRENCE G. WASDEN, ATTORNEY GENERAL OF THE STATE OF IDAHO; and

STATE OF SOUTH DAKOTA, by and through MARTY J. JACKLEY, ATTORNEY GENERAL OF THE STATE OF SOUTH DAKOTA;

Plaintiffs,

v. **Case No. 3:10-cv-91**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHLEEN SEBELIUS, in her official capacity as the Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF THE TREASURY; TIMOTHY F. GEITHNER, in his official capacity as the Secretary of the United States Department of the Treasury; UNITED STATES DEPARTMENT OF LABOR; and HILDA L. SOLIS, in her official capacity as Secretary of the United States Department of Labor,

Defendants.

_____/

COMPLAINT

Plaintiffs, STATE OF FLORIDA, by and through BILL McCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA; STATE OF SOUTH CAROLINA, by and through HENRY McMASTER, ATTORNEY GENERAL OF THE STATE OF SOUTH CAROLINA; STATE OF NEBRASKA, by and through JON

BRUNING, ATTORNEY GENERAL OF THE STATE OF NEBRASKA; STATE OF TEXAS, by and through GREG ABBOTT, ATTORNEY GENERAL OF THE STATE OF TEXAS; STATE OF UTAH, by and through MARK L. SHURTLEFF, ATTORNEY GENERAL OF THE STATE OF UTAH; STATE OF LOUISIANA, by and through JAMES D. "BUDDY" CALDWELL, ATTORNEY GENERAL OF THE STATE OF LOUISIANA; STATE OF ALABAMA, by and through TROY KING, ATTORNEY GENERAL OF THE STATE OF ALABAMA; STATE OF MICHIGAN, by and through MICHAEL A. COX, ATTORNEY GENERAL OF THE STATE OF MICHIGAN; STATE OF COLORADO, by and through JOHN W. SUTHERS, ATTORNEY GENERAL OF THE STATE OF COLORADO; COMMONWEALTH OF PENNSYLVANIA, by and through THOMAS W. CORBETT, Jr., ATTORNEY GENERAL OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF WASHINGTON, by and through ROBERT M. McKENNA, ATTORNEY GENERAL OF THE STATE OF WASHINGTON; STATE OF IDAHO, by and through LAWRENCE G. WASDEN, ATTORNEY GENERAL OF THE STATE OF IDAHO; and STATE OF SOUTH DAKOTA, by and through MARTY J. JACKLEY, ATTORNEY GENERAL OF THE STATE OF SOUTH DAKOTA, file this action against Defendants, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS); KATHLEEN SEBELIUS, in her official capacity as the Secretary of HHS; UNITED STATES DEPARTMENT OF THE TREASURY (Treasury); TIMOTHY F. GEITHNER, in his official capacity as the Secretary of the Treasury; UNITED

STATES DEPARTMENT OF LABOR (DOL); and HILDA L. SOLIS, in her official capacity as the Secretary of DOL, and state:

NATURE OF THE ACTION

1. On March 23, 2010, a new universal healthcare regime, titled the "Patient Protection and Affordable Care Act," H.R. 3590 (the Act), was signed into law by the President. The Act, which exceeds 2,400 pages, is available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590pp.txt.pdf (accessed March 23, 2010).

2. The Act represents an unprecedented encroachment on the liberty of individuals living in the Plaintiffs' respective states, by mandating that all citizens and legal residents of the United States have qualifying healthcare coverage or pay a tax penalty. The Constitution nowhere authorizes the United States to mandate, either directly or under threat of penalty, that all citizens and legal residents have qualifying healthcare coverage. By imposing such a mandate, the Act exceeds the powers of the United States under Article I of the Constitution and violates the Tenth Amendment to the Constitution.

3. In addition, the tax penalty required under the Act, which must be paid by uninsured citizens and residents, constitutes an unlawful capitation or direct tax, in violation of Article I, sections 2 and 9 of the Constitution of the United States.

4. The Act also represents an unprecedented encroachment on the sovereignty of the states. For example, it requires that Florida vastly broaden its Medicaid eligibility standards to accommodate upwards of 50 percent more enrollees,

many of whom must enroll or face a tax penalty under the Act, and imposes onerous new operating rules that Florida must follow. The Act requires Florida to spend billions of additional dollars, and shifts substantial administrative costs to Florida for, *inter alia*, hiring and training new employees, as well as requiring that new and existing employees devote a considerable portion of their time to implementing the Act. This onerous encroachment occurs at a time when Florida faces having to make severe budget cuts to offset shortfalls in its already-strained budget, which the state constitution requires to be balanced each fiscal year (unlike the federal budget), and at a time when Florida's Medicaid program already consumes more than a quarter of the State's financial outlays. Plaintiffs cannot effectively withdraw from participating in Medicaid, because Medicaid has, over the more than four decades of its existence, become customary and necessary for citizens throughout the United States, including the Plaintiffs' respective states; and because individual enrollment in Plaintiffs' respective Medicaid programs, which presently cover tens of millions of residents, can only be accomplished by their continued participation in Medicaid.

5. Further, the Act converts what had been a voluntary federal-state partnership into a compulsory top-down federal program in which the discretion of the Plaintiffs and their sister states is removed, in derogation of the core constitutional principle of federalism upon which this Nation was founded. In so doing, the Act exceeds the powers of the United States and violates the Tenth Amendment to the Constitution.

6. The Act contains several unfunded mandates that will cost state governments significantly.

7. For example, no Florida government entity or infrastructure exists to discharge sufficiently all of the responsibilities that will be necessary to implement the Act, to meet requirements related to increases in Medicaid enrollment under the Act, and to operate healthcare insurance exchanges required by the Act.

8. By making federal funds potentially available at the discretion of federal agencies, the Act acknowledges the immediate burden on Plaintiffs to invest and implement the Act, but provides no guarantee that they will receive such funds or that the Act's implementation costs will be met.

9. Plaintiffs seek declaratory and injunctive relief against the Act's operation to preserve their respective sovereignty and solvency, and to protect the individual freedom, public health, and welfare of their citizens and residents.

JURISDICTION AND VENUE

10. The Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331 because this action arises under the Constitution and laws of the United States.

11. Venue is proper in this district pursuant to 28 U.S.C. § 1391(e)(3) because no real property is involved, the district is situated in Florida, and the defendants are agencies of the United States or officers thereof acting in their official capacity.

PARTIES

12. The State of Florida is a sovereign state and protector of the individual freedom, public health, and welfare of its citizens and residents. Bill McCollum,

Attorney General of Florida, has been directly elected by the people of Florida to serve as their chief legal officer and exercises broad statutory and common law authority to protect the rights of the State of Florida and its people; Fla. Const. art. IV, § 4(b). The State, by and through the Attorney General, has standing to assert the unconstitutionality of the Act. He is authorized to appear in and attend all suits in which the state is interested. § 16.02(4) & (5), Fla. Stat.

13. The State of South Carolina, by and through Henry McMaster, Attorney General of South Carolina, is a sovereign state in the United States of America.

14. The State of Nebraska, by and through Jon Bruning, Attorney General of Nebraska, is a sovereign state in the United States of America.

15. The State of Texas, by and through Greg Abbott, Attorney General of Texas, is a sovereign state in the United States of America.

16. The State of Utah, by and through Mark L. Shurtleff, Attorney General of Utah, is a sovereign state in the United States of America.

17. The State of Alabama, by and through Troy King, Attorney General of Alabama, is a sovereign state in the United States of America.

18. The State of Louisiana, by and through James D. "Buddy" Caldwell, Attorney General of Louisiana, is a sovereign state in the United States of America.

19. The State of Michigan, by and through Michael A. Cox, Attorney General of Michigan, is a sovereign state in the United States of America.

20. The State of Colorado, by and through John W. Suthers, Attorney General of Colorado, is a sovereign state in the United States of America.

21. The Commonwealth of Pennsylvania, by and through Thomas W. Corbett, Jr., Attorney General of Pennsylvania, is a sovereign state in the United States of America.

22. The State of Washington, by and through Robert A. McKenna, Attorney General of Washington, is a sovereign state in the United States of America.

23. The State of Idaho, by and through Lawrence G. Wasden, Attorney General of Idaho, is a sovereign state in the United States of America.

24. The State of South Dakota, by and through Marty J. Jackley, Attorney General of South Dakota, is a sovereign state in the United States of America

25. HHS is an agency of the United States, and is responsible for administration and enforcement of the Act, through its center for Medicare and Medicaid Services.

26. Kathleen Sebelius is Secretary of HHS, and is named as a party in her official capacity.

27. Treasury is an agency of the United States, and is responsible for administration and enforcement of the Act.

28. Timothy F. Geithner is Secretary of the Treasury, and is named as a party in his official capacity.

29. DOL is an agency of the United States, and is responsible for administration and enforcement of the Act.

30. Hilda L. Solis is Secretary of DOL, and is named as a party in her official capacity.

BACKGROUND

The Medicaid Program Prior to the Act

31. Medicaid was established by Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396 *et seq.*, as the nation's major healthcare initiative for low-income persons. Each participating state's Medicaid program has been funded jointly by the state and the federal government.

32. From the beginning of Medicaid until passage of the Act, the states were given considerable discretion to implement and operate their respective optional Medicaid programs in accordance with state-specific designs regarding eligibility, enrollment, and administration, so long as the programs met broad federal requirements.

33. The states were free to opt out of Medicaid and set up their own state health or welfare plans, or to provide no such benefits at all. States, including Plaintiffs, agreed to participate in Medicaid with the understanding that their continuing participation was voluntary, as a matter of both law and fact.

34. None of the Plaintiffs agreed to become a Medicaid partner of the federal government with an expectation that the terms of its participation would be altered significantly by the federal government so as to make it financially infeasible for that state either to remain in or to withdraw from the Medicaid program.

35. None of the Plaintiffs agreed to become a Medicaid partner of the federal government with an expectation that the federal government would increase significantly its control and reduce significantly that state's discretion with respect to the Medicaid program.

36. None of the Plaintiffs agreed to become a Medicaid partner of the federal government with an expectation that, after the Medicaid program became entrenched in the state, the federal government would alter the program's requirements to expand eligibility for enrollment beyond the state's ability to fund its participation.

37. None of the Plaintiffs agreed to become a Medicaid partner of the federal government with an expectation that the federal government would exploit its control over Medicaid terms and eligibility as part of a coercive scheme to force all citizens and residents to have healthcare coverage.

The Patient Protection and Affordable Care Act

38. The Act mandates that all United States citizens and legal residents have qualifying healthcare coverage. If a person fails to do so, the federal government will force that person to pay a penalty, the amount of which will be increased gradually through 2016, reaching $750 per year up to a maximum of three times that amount ($2,250) per family, or 2 percent of household income, whichever is greater. After 2016, the penalty will increase annually based on a cost-of-living adjustment. Exemptions to the tax penalty only apply for individuals with certain religious objections, American Indians, those persons without coverage for less than three months, undocumented immigrants, incarcerated individuals, or some individuals with financial hardships.

39. The Act greatly alters the federal-state relationship, to the detriment of the states, with respect to Medicaid programs specifically and healthcare coverage generally.

40. The Act requires states to expand massively their Medicaid programs and to create exchanges through which individuals can purchase healthcare insurance

coverage. The federal government is to provide partial funding for the exchanges, but will cease doing so after 2015. Should a state not wish to participate in the exchanges, it can opt out only if it provides coverage for uninsured individuals with incomes between 133 percent and 200 percent of the federal poverty level, a higher income level than that which would be applied for participating states under the Act. The only other way for a state to avoid the Act's requirements is to drop out of the Medicaid program, leaving millions of persons uninsured.

41. Those states left with no practical alternative but to participate in the Act will have to expand their Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level. The states' coverage burdens will increase significantly after 2016, both in actual dollars and in proportion to the contributions of the federal government.

42. The federal government will not provide necessary funding or resources to the states to administer the Act. Nevertheless, states will be required to provide oversight of the newly-created insurance markets, including, *inter alia*, instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. States also must enroll all of the newly-eligible Medicaid beneficiaries (many of whom will be subject to a penalty if they fail to enroll), coordinate enrollment with the new exchanges, and implement other specified changes. The Act further requires states to establish an office of health insurance consumer assistance or an ombudsman program to advocate for people in the new programs.

The Act's Impact on Florida's Medicaid Program, as an Example

43. The Act will have an impact on all Plaintiffs and in a manner similar to its impact on Florida, as described herein by way of example.

44. Florida is the Nation's fourth largest state in population. Based on United States Census Bureau statistics from 2008, Florida has 3,641,933 uninsured persons living in the state. Of those persons, 1,259,378 are below 133 percent of the federal poverty line, and therefore must be added to Florida's Medicaid rolls under the Act.

45. Even before passage of the Act, the Medicaid program imposed an overwhelming cost on Florida, consuming 26 percent of its annual budget. For fiscal year 2009-2010 alone, Florida will spend more than $18 billion on Medicaid, servicing more than 2.7 million persons. Florida's Medicaid contributions and burdens, from the implementation of its Medicaid program in 1970 to the present, have gradually increased to the point where it would be infeasible for Florida to cease its participation in Medicaid.

46. Although the federal government currently contributes 67.64 percent of every dollar Florida spends on Medicaid, that percentage is artificially and temporarily raised because of federal stimulus outlays. After this year, the percentage of Florida's Medicaid program expenses covered by the federal government will decline, and by 2011 will reach 55.45 percent, a level that is closer to the recent average. The federal government's contribution will not compensate for the dramatic increase to Florida's Medicaid rolls and the correspondingly soaring costs to be borne by Florida under the Act.

47. Florida's Agency for Health Care Administration (AHCA) estimates that at least 80 percent of persons who have some form of health insurance but fall below 133 percent of the federal poverty level will drop their current plans and enroll in Medicaid, because they are newly eligible under the Act. The federal government does not offer any funding for these persons, because they qualified for insurance other than Medicaid prior to passage of the Act. These persons represent a significant additional cost to Florida under the Act.

48. The Act also makes a large new class of persons eligible for Medicaid in Florida. Prior to passage of the Act, only certain specified low-income individuals and families qualified for Medicaid. Moreover, the qualifying income level set by Florida was much lower than the level of 133 percent of the federal poverty line set by the federal government under the Act. Now, Florida also must add to its Medicaid rolls all childless adults whose income falls below 133 percent of the federal poverty line.

49. Prior to passage of the Act, AHCA was Florida's designated state Medicaid agency tasked with developing and carrying out policies related to the Medicaid program. The Act will strip away much of AHCA's authority to set policies, transferring that authority to the federal government, which will dictate those policies to Florida. AHCA and the other Florida agencies will be rendered arms of the federal government, and AHCA employees will be conscripted and forced to administer what now is essentially a federal Medicaid program for which Florida must bear a substantial cost.

50. AHCA has prepared limited projections for the fiscal impact of the Act. The new additional costs to the state are as follows: $149,001,478 for 2014; $431,307,547 for 2015; $484,803,557 for 2016; $938,807,336 for 2017; $993,836,882 for 2018, and $1,048,866,307 for 2019. Beyond this time frame, the costs to Florida will continue to grow. These projections understate the Act's adverse impact on Florida. They do not include estimated costs to be borne by Florida to administer the Act or to prepare for the Act's implementation. Such costs will include hiring and training new staff, creating new information technology infrastructures, developing an adequate provider base, creating a scheme for accountability and quality assurance, and many other expenses.

51. The Act effectively requires that Florida immediately begin to devote funds and resources to implement the Act's sweeping reforms across multiple agencies of government. Such implementation burdens include, but are not limited to: enforcing the Act's immediately-effective terms, including new mandates regarding healthcare insurance coverage; determining gaps between current resources in state government and the Act's requirements; evaluating infrastructure to consider how new programs and substantial expansion of existing programs will be implemented (e.g., new agencies, offices, etc.); developing a strategic plan and coordinating common issues across state agencies; initiating legislative and regulatory processes, while at the same time monitoring and engaging the substantial federal regulatory processes to ensure that Florida's interests are protected; and developing a communications structure and plan to disseminate new information regarding changes brought about by the Act to the many

affected persons and entities (legislators, state agencies, insurers, hospitals, doctors, community clinics, major employers, small businesses, advocacy groups, insurance brokers, legislators, the uninsured, and Floridians generally), and to achieve such dissemination in sufficient time for them to understand and adapt to the changes in accordance with federal timetables, without interruption or confusion in the provision of healthcare services.

52. In sum, while the Act infringes on Florida's constitutional status as a sovereign, entitled to cooperate with but not to be controlled by the federal government under the Medicaid program, the Act also will force Florida to cover more than one million additional persons and, in so doing, to spend billions of additional dollars, a price it simply cannot afford to pay.

53. At the same time, like the other Plaintiffs, Florida cannot avoid the Act's requirements by ending its longstanding participation in the Medicaid program, thereby leaving millions of current Medicaid recipients stranded without coverage. In effect, the Plaintiffs' participation under the Act cannot be avoided, despite its devastating effects.

CAUSES OF ACTION

COUNT ONE

UNCONSTITUTIONAL EXERCISE OF FEDERAL POWER AND VIOLATION OF THE TENTH AMENDMENT (Const. art. I & amend. X)

54. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 53 above as though fully set forth herein.

55. Plaintiffs cannot afford the exorbitant and unfunded costs of participating under the Act, but have no choice other than to participate.

56. The Act exceeds Congress's powers under Article I of the Constitution of the United States, and cannot be upheld under the Commerce Clause, Const. art. I, §8; the Taxing and Spending Clause, id.; or any other provision of the Constitution.

57. By effectively co-opting the Plaintiffs' control over their budgetary processes and legislative agendas through compelling them to assume costs they cannot afford, and by requiring them to establish health insurance exchanges, the Act deprives them of their sovereignty and their right to a republican form of government, in violation of Article IV, section 4 of the Constitution of the United States.

58. The Act violates the Tenth Amendment of the Constitution of the United States, and runs afoul of the Constitution's principle of federalism, by commandeering the Plaintiffs and their employees as agents of the federal government's regulatory scheme at the states' own cost.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act to be in violation of Article I of and the Tenth Amendment to the Constitution of the United States;

B. Declare Defendants to have violated the Plaintiffs' rights as sovereigns and protectors of the freedom, public health, and welfare of their citizens and residents, as aforesaid;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiffs, their citizens and

residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their reasonable attorney's fees and costs, and grant such other relief as the Court may deem just and proper.

COUNT TWO

VIOLATION OF CONSTITUTIONAL PROHIBITION OF UNAPPORTIONED CAPITATION OR DIRECT TAX (Const. art. I, §§ 2, 9)

59. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 53 above as though fully set forth herein.

60. The tax penalty on uninsured persons under the Act constitutes a capitation and a direct tax that is not apportioned among the states according to census data, thereby injuring the sovereign interests of Plaintiffs.

61. Said tax penalty applies without regard to property, profession, or any other circumstance, and is unrelated to any taxable event or activity. It is to be levied upon persons for their failure or refusal to do anything other than to exist and reside in the United States.

62. Said tax penalty violates article I, sections 2 and 9 of the Constitution of the United States. By its imposition of the penalty tax, and by the resulting coercion of many persons to enroll in Medicaid at a substantial cost to the Plaintiffs, the Act injures their interests as sovereigns vested with exclusive authority, except to the extent permitted to the federal government by the Constitution, to make all taxing decisions

affecting their citizens and to confer a right upon persons in their states to make healthcare decisions without government interference. The tax penalty is unconstitutional on its face and cannot be applied constitutionally.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act to be in violation of Article I, sections 2 and 9 of the Constitution of the United States;

B. Declare Defendants to have violated the Plaintiffs' rights as sovereigns and protectors of the freedom, public health, and welfare of their citizens and residents, as aforesaid;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiffs, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their reasonable attorney's fees and costs, and grant such other relief as the Court may deem just and proper.

COUNT THREE

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTH INSURANCE COVERAGE OR PAY TAX PENALTY
(Const. art. I & amend. X)

63. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 53 above as though fully set forth herein.

64. The Act forces citizens and residents to have healthcare coverage or pay a tax penalty. In effect, the Act compels said persons to have healthcare coverage, whether or not they wish to do so, or be subject to sanction. The Act thus compels persons to perform an affirmative act or incur a penalty, simply on the basis that they exist and reside in the United States.

65. The Act is directed to a lack of or failure to engage in activity that is driven by the choices of individual Americans. Such inactivity by its nature cannot be deemed to be in commerce or to have any substantial effect on commerce, whether interstate or otherwise. As a result, the Act cannot be upheld under the Commerce Clause, Const. art. I, § 8. The Act infringes upon Plaintiffs' interests in protecting the freedom, public health, and welfare of their citizens and their state fiscs, by coercing many persons to enroll in Medicaid at a substantial cost to Plaintiffs; and denies Plaintiffs their sovereign ability to confer rights upon their citizens and residents to make healthcare decisions without government interference, including the decision not to participate in any healthcare insurance program or scheme, in violation of the Tenth Amendment to the Constitution of the United States.

66. The tax penalty on uninsured persons under the Act unlawfully coerces persons to obtain healthcare coverage, thereby injuring the Plaintiffs' fiscs, because many persons will be compelled to enroll in Medicaid at a substantial cost to Plaintiffs. As a result, the Act cannot be upheld under the Taxing and Spending Clause, Const. art. I, § 8.

67. In so coercing citizens and residents to have healthcare coverage, the Act exceeds Congress's powers under Article I of the Constitution of the United States, and cannot be upheld under any provision of the Constitution.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act to be in violation of Article I, section 8 of and the Tenth Amendment to the Constitution of the United States;

B. Declare Defendants to have violated the Plaintiffs' rights as sovereigns and protectors of the freedom, health, and welfare of their citizens and residents, as aforesaid;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiffs, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their reasonable attorney's fees and costs, and grant such other relief as the Court may deem just and proper.

COUNT FOUR

DECLARATORY JUDGMENT (28 U.S.C. § 2201)

68. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 53 above as though fully set forth herein.

69. There is an actual controversy of sufficient immediacy and concreteness relating to the legal rights and duties of the Plaintiffs and their legal relations with the Defendants to warrant relief under 28 U.S.C. § 2201.

70. The harm to the Plaintiffs as a direct result of the Act is sufficiently real and imminent to warrant the issuance of a conclusive declaratory judgment clarifying the legal relations of the parties.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act to be in violation of Article I of and the Tenth Amendment to the Constitution of the United States;

B. Declare Defendants to have violated the Plaintiffs' rights as sovereigns and protectors of the freedom, health, and welfare of their citizens and residents, as aforesaid;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiffs, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their reasonable attorney's fees and costs, and grant such other relief as the Court may deem just and proper.

Respectfully submitted,

BILL MCCOLLUM
ATTORNEY GENERAL OF FLORIDA

HENRY McMASTER
ATTORNEY GENERAL OF SOUTH CAROLINA;

JON BRUNING
ATTORNEY GENERAL OF NEBRASKA;

GREG ABBOTT
ATTORNEY GENERAL OF TEXAS;

MARK L. SHURTLEFF
ATTORNEY GENERAL OF UTAH;

JAMES D. "BUDDY" CALDWELL
ATTORNEY GENERAL OF LOUISIANA;

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EXHIBIT E

STATE OF WASHINGTON	STATE OF MICHIGAN	STATE OF COLORADO	COMMONWEALTH OF PENNSYLVANIA

March 26, 2010

The Honorable Eric Holder, Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

RE: *State of Florida, et al v. United States*

Dear Attorney General Holder:

On behalf of citizens of our states, we write to let you know that that we oppose the actions of the state Attorneys General who have filed a lawsuit to challenge the constitutionality of the Patient Protection and Affordable Care Act. We believe their legal efforts will fail in court, unnecessarily delay the urgent need to get our citizens access to health care and waste our state tax dollars. As you prepare and deliver your defense of this landmark legislation, you have our commitment to work with you, at your request, to assist in this effort.

The Patient Protection and Affordable Care Act is, in our view, the single most important reform of our health care system in decades. The bill gives American families and small business owners more control over their own health care. It shifts health care decision making authority away from insurance companies to the citizens whose health is at risk. It ends discrimination against people with pre-existing conditions and allows young people to remain covered by their parents' insurance until age twenty-six. As our states struggle to balance budgets and maintain services, the savings introduced through this legislation are critical to our future.

We are ready to offer you any help you many need and we will stand by your efforts to protect this most historic improvement of health care for every citizen of this nation

Sincerely,

Governor Christine O. Gregoire
Washington

Governor Jennifer M. Granholm
Michigan

Governor Bill Ritter, Jr.
Colorado

Governor Edward G. Rendell
Pennsylvania